



Outpatient Services • Clinics and Hospitals

April 2006 • Bulletin 378

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Laboratory Service Frequency Limits Clarification

Retroactive to dates of service on or after January 5, 2004, laboratory services are subject to frequency limits. These limits are set per recipient, per service, per month via the Laboratory Services Reservation System (LSRS). Laboratory providers may use the LSRS to make reservations, or verify if a frequency limit has been reached for a specific recipient for a specific laboratory service prior to performing the procedure. When a reservation is made, the claim must be billed with the provider number used to make the reservation.

Frequency limits may be overridden on a case-by-case basis when the provider submits medical justification to support the frequency of the laboratory service for a recipient. Justification will be reviewed by medical review staff for final authorization. Providers are reminded that laboratory service claims that are denied due to frequency limitations may be appealed with submission of medical justification. Failure to make a laboratory service reservation prior to performing the laboratory service may result in denial of the claim.

The following entities are excluded from frequency limitations when the full laboratory service is rendered onsite: End Stage Renal Disease (Dialysis) Clinics, county public health clinics, Skilled Nursing Facilities (SNFs), inpatient hospitals and emergency rooms. The following programs are excluded from frequency limitations: California Children's Services, Genetically Handicapped Persons Program and Child Health and Disability Prevention Program.

Note: Providers are reminded that independent clinical laboratories that provide services to recipients in SNFs and dialysis clinics must adhere to the same requirements to supply their claims with further documentation in support of medical justification for rendering laboratory services to these recipients.

For an overview of the LSRS process, providers can go to:

<http://pro.medi-cal.ca.gov/Docs/Elearning/LSRS3028/HTML/HOME.htm>

This information is reflected on manual replacement page path an over 7 (Part 2).

Recording Anesthesia Time Clarification

Providers are reminded to document time spent with a patient during obstetrical regional anesthesia in minutes as actual time spent (ACTM), not as a range of time.

Examples:

- "ACTM = 15 minutes" is acceptable documentation.
- "ACTM = 2300 – 0100" is unacceptable documentation and therefore the claim will be denied.

This updated information is reflected on manual replacement page anest 2 (Part 2).

New Blood Factor Billing Method for Pharmacy Providers Coming Soon

Effective for dates of service on or after July 1, 2006, pharmacy providers must bill Blood Factor and Anti-Hemophilia Factor products using National Drug Codes instead of billing “By Report.” Providers can submit claims hard copy or electronically. However, providers who bill for California Children’s Services (CCS)-only, CCS/Healthy Families, Genetically Handicapped Persons Program (GHPP)-only eligible recipients, or for Medi-Cal/CCS/GHPP-eligible recipients with a CCS or GHPP Legacy or a CCS Service Authorization Request, must continue to bill hard copy with the required authorization by the Children’s Medical Services Branch.

All other provider types must continue to bill using the “By Report” methodology currently in place using the *HCFA 1500* claim form.

Medi-Cal will continue to reimburse providers the lesser of the manufacturer’s Average Selling Price plus 20 percent or the provider’s usual and customary charge.

Provider manual pages regarding this policy will be updated in a future *Medi-Cal Update*.

Exceptions to Submitting CIFs

Providers are reminded not to submit *Claims Inquiry Forms* (CIFs) for the following Remittance Advice Details (RAD) code messages, unless information on the CIF specifically addresses the denial reason. For example, if the denial was 002, but an error is found in the recipient ID on the original claim, this would be an appropriate CIF, with a changed recipient ID. However, if providers wish to challenge the determination, a CIF will result in the same denial. A review by a person in the appeals unit is the only way of resolving denials if the claim has a unique circumstance needing human intervention.

<u>Code</u>	<u>Message</u>
0002	The recipient is not eligible for benefits under the Medi-Cal program or other special programs.
0010	This service is a duplicate of a previously paid claim.
0072	This service is included in another procedure code billed on the same date of service.
0095	This service is not payable due to a procedure, or procedure and modifier, previously reimbursed.
0314	Recipient not eligible for the month of service billed.
0326	Another procedure with a primary surgeon modifier has been previously paid for the same recipient on the same date of service.

The updated information is reflected on manual replacement page [cif co 2](#) (Part 2).

BCCTP Referral Reminder

Providers are reminded that the Breast and Cervical Cancer Treatment Program (BCCTP) offers treatment through the Medi-Cal program for individuals with breast or cervical cancer who meet the program's financial eligibility criteria. Recipients can only gain access to BCCTP through Cancer Detection Programs: Every Woman Counts primary care providers and Family PACT (Planning, Access, Care and Treatment) providers.

Diagnoses Obtained Through Cancer Detection Programs: Every Woman Counts

Women already in Cancer Detection Programs: Every Woman Counts and diagnosed with breast cancer and/or cervical cancer (including CIN II and CIN III) can be referred to BCCTP. Providers should fill in the box on the Cancer Detection Programs: Every Woman Counts breast and/or cervical data form that states, "*Patient referred to treatment,*" then follow BCCTP enrollment procedures.

Men are not eligible to enter BCCTP through Cancer Detection Programs: Every Woman Counts. They must be diagnosed by a Family PACT provider.

Diagnoses Obtained Outside Cancer Detection Programs: Every Woman Counts

Women age 25 and above who are diagnosed with cervical cancer may be enrolled into BCCTP by Cancer Detection Programs: Every Woman Counts providers. In these cases, the program provider must confirm that the woman has documentation of either breast cancer and/or cervical cancer (including CIN II and CIN III). Additionally, the provider must verify that the woman self-reports as meeting program and financial criteria for Cancer Detection Programs: Every Woman Counts by filling out the recipient eligibility form.

Providers complete the form and fill in the box that indicates the patient is being referred to BCCTP. The form may state either, "Check this box if recipient is being enrolled into Cancer Detection Programs: Every Woman Counts in order to be enrolled into the Breast and Cervical Treatment Program. No Cancer Detection Programs: Every Woman Counts services are needed at this time" or "Recipient referred for Breast and Cervical Cancer Treatment Program (optional)." The provider must keep recipient-signed documentation of the recipient eligibility form on file. Providers then are to follow BCCTP enrollment procedures.

Providers can not bill Cancer Detection Programs: Every Woman Counts for an office visit if the only reason the recipient sees the primary care physician is for referral into BCCTP. The claim must be billed through BCCTP.

Billing Data Requirements

If a provider determines more testing is needed for a woman diagnosed outside Cancer Detection Programs: Every Woman Counts before confirming a cancer diagnosis, the provider may perform testing under the cancer program. The provider must understand that once billing occurs in Cancer Detection Programs: Every Woman Counts, the same data requirements apply as if the patient was screened within the program. This means a complete screening cycle data must be submitted on the online screening forms.

For more BCCTP information, contact the Eligibility Specialist at 1-800-824-0088. Additional information can be found in the Medi-Cal provider manual and at www.medi-cal.ca.gov.

This updated information is reflected on manual replacement pages can detect 5 thru 12 (Part 2).

**Cancer Detection Programs: Every Woman Counts
Recipient Eligibility Forms Update**

The two Cancer Detection Programs: Every Woman Counts recipient eligibility forms (Form A and Form B) have been replaced with a single version, available in both English and Spanish. The new versions of the *Recipient Eligibility Form* are found at the end of the *Cancer Detection Programs: Every Woman Counts* section of the appropriate Part 2 manual.

Enrollment Delays into Cancer Detection Programs: Every Woman Counts

Cancer Detection Programs: Every Woman Counts providers will experience delays enrolling women in the program due to:

- Change in ownership
- Converting between a Rural Health Clinics/Federally Qualified Health Clinics (RHC/FQHC) number and a regular Medi-Cal provider number
- Change of name or address

Providers making these changes must complete the following steps in order to secure enrollment of women into Cancer Detection Programs: Every Woman Counts.

Change in Ownership or Conversions

After a change in ownership or converting between a RHC/FQHC and a regular Medi-Cal provider number, the provider is assigned a new Medi-Cal provider number. This requires a new enrollment with Cancer Detection Programs: Every Woman Counts. Providers cannot offer services until their new provider number is added to the Provider Master File (PMF) with a Cancer Detection Programs: Every Woman Counts category of service. This does not happen automatically, and takes four to six weeks. Women with immediate needs must be referred to another Cancer Detection Programs: Every Woman Counts provider.

A new Provider Enrollment Agreement (PEA) must be filed with the new provider number. Providers must contact their Regional Cancer Detection Partnership to initiate the enrollment process of their new number. Refer to section 5 in the Program Manual for Primary Care Providers, which can be found on the provider support page at www.dhs.ca.gov/cancerdetection/providersupport.htm.

New Provider Name or Address Change

When a new provider enrolls with Cancer Detection Programs: Every Woman Counts and the name or address on the Provider Action Form (PAF) does not coincide with the PMF, the provider must contact Licensing and Certification (for clinics or hospitals) or Provider Enrollment (for individual providers) by submitting a Medi-Cal Supplemental Application.

Providers cannot enroll until their information is changed in the PMF. For faster processing, please ensure that all paperwork submitted is complete and accurate.

Existing Provider Name or Address Change

When an existing Cancer Detection Programs: Every Woman Counts provider changes their name or address, the provider must contact Licensing and Certification (for clinics or hospitals) or Provider Enrollment (for individual providers) by submitting a Medi-Cal Supplemental Application, and submit a new PEA and *Cancer Detection Programs: Every Woman Counts, Consumer 800 number, Provider Information Survey* within 60 days of the change.

Presumptive Eligibility Program 2006 Poverty Level Income Guidelines

The 2006 Federal Poverty Income Guidelines are effective April 1, 2006 through March 31, 2007. The guidelines are used to determine eligibility for Presumptive Eligibility (PE) program services for pregnant women. Applicants are eligible if their gross family incomes are at or below the revised poverty levels shown in the following table. The applicant's unborn child is counted as a member of the family; therefore, the guidelines begin with two persons (the mother and her unborn child). For specific PE questions, call the Telephone Service Center (TSC) at 1-800-541-5555.

Please see PE Income Guidelines, page 5

PE Income Guidelines (*continued*)**FEDERAL POVERTY INCOME GUIDELINES**

200 Percent of Poverty by Family Size

Number of Persons	Gross Monthly Income	Gross Annual Income
2	\$ 2,200	\$ 26,400
3	\$ 2,767	\$ 33,200
4	\$ 3,334	\$ 40,000
5	\$ 3,900	\$ 46,800
6	\$ 4,467	\$ 53,600
7	\$ 5,034	\$ 60,400
8	\$ 5,600	\$ 67,200
9	\$ 6,167	\$ 74,000
10	\$ 6,734	\$ 80,800
For each additional person, add	\$ 567	\$ 6,800

This updated information is reflected on manual replacement page presum 6 (Part 2).

**Family PACT 2006 Poverty Level Income Guidelines**

The 2006 Federal Poverty Income Guidelines are effective for the Family PACT (Planning, Access, Care and Treatment) Program for dates of service on or after May 1, 2006. The guidelines are used to determine financial eligibility for the program. Applicants are eligible if their gross family incomes are at or below the revised poverty levels shown in the following table.

FEDERAL POVERTY INCOME GUIDELINES

200 Percent of Poverty by Family Size

Number of Persons	Monthly Income	Annual Income
1	\$ 1,634	\$ 19,600
2	\$ 2,200	\$ 26,400
3	\$ 2,767	\$ 33,200
4	\$ 3,334	\$ 40,000
5	\$ 3,900	\$ 46,800
6	\$ 4,467	\$ 53,600
7	\$ 5,034	\$ 60,400
8	\$ 5,600	\$ 67,200
9	\$ 6,167	\$ 74,000
10	\$ 6,734	\$ 80,800
For each additional person, add	\$ 567	\$ 6,800

Revised *Family PACT Policies, Procedures and Billing Instructions* (PPBI) manual pages will be issued in a future mailing to Family PACT providers. For more information about Family PACT, call the Telephone Service Center (TSC) at 1-800-541-5555 from 8 a.m. to 5 p.m. Monday through Friday, except holidays, or visit the Family PACT Web site at www.familypact.org.

CHDP 2006 Poverty Level Income Guidelines

The 2006 Federal Poverty Income Guidelines are effective April 1, 2006 through March 31, 2007. The guidelines are used to determine eligibility for the Child Health and Disability Prevention (CHDP) program. Applicants are eligible if their gross family incomes are at or below the revised poverty levels shown in the following chart.

For additional CHDP information, call the Telephone Service Center (TSC) at 1-800-541-5555.

FEDERAL POVERTY INCOME GUIDELINES

200 Percent of Poverty by Family Size

Number of Persons	Gross Monthly Income	Gross Annual Income
1	\$ 1,634	\$ 19,600
2	\$ 2,200	\$ 26,400
3	\$ 2,767	\$ 33,200
4	\$ 3,334	\$ 40,000
5	\$ 3,900	\$ 46,800
6	\$ 4,467	\$ 53,600
7	\$ 5,034	\$ 60,400
8	\$ 5,600	\$ 67,200
9	\$ 6,167	\$ 74,000
10	\$ 6,734	\$ 80,800
For each additional person, add	\$ 567	\$ 6,800

CCS/GHPP SAR Exceptions Update

Effective for dates of service on or after April 1, 2006, California Children's Services (CCS) and Genetically Handicapped Persons Program (GHPP) providers need a separate Service Authorization Request (SAR) for the following drugs, factors and nutritional products:

- Anti-Inhibitors (J7198)
- Factor VIIa Recombinant (Q0187)
- Minerals/Protein Replacements/Supplements
- Sildenafil
- Tadalafil
- Vardenafil
- Von Willebrand Factors (Q2022)

In addition, effective for dates of service on or after April 1, 2006, Factor VIIa Recombinant should be billed using HCPCS code Q0187. HCPCS code Z5230 will no longer be an active code.

This updated information is reflected on manual replacement page cal child sar 6 (Part 2).



Upcoming Vision Care Changes in July 2006

As part of the continuing effort to comply with the federally mandated Health Insurance Portability and Accountability Act (HIPAA), the following vision changes will become effective for dates of services on or after July 1, 2006:

- **Vision Electronic Claim Submitters:**
 - Medi-Cal will **discontinue** acceptance of non-HIPAA standard electronic formats for vision claim transactions. **REGARDLESS of Date of Service**, as of July 1, 2006, the California Department of Health Services (CDHS) will no longer accept the Vision Computer Media Claim (CMC) proprietary format. Electronic claims must be billed using the HIPAA-compliant ASC X12N 837 Professional version 4010A1 format or Internet Professional Claims Submission System (IPCS).
 - ASC X12N 837 v.4010A1 Vision Companion Guide will be replaced with the ASC X12N 837 v.4010A1 Medical Companion Guide for dates of service on or after July 1, 2006. The companion guides can be found in the “HIPAA Update” area of the Medi-Cal Web site (www.medi-cal.ca.gov).
- **Vision Paper Claim Submitters:**
 - Paper claims must be billed on the *HCFA 1500* claim form. Medi-Cal’s proprietary *Payment Request for Vision Care and Appliances* (45-1) claim form will no longer be accepted.
- **New Vision TAR Procedures:**
 - As a result of the discontinuance of the *Payment Request for Vision Care and Appliances* (45-1) claim form previously used to request prior authorization for eye appliances, a new *Treatment Authorization Request* (TAR) form (50-3) has been created for this purpose. Watch for future *Medi-Cal Updates* and announcements on the Medi-Cal Web site for details about this new form and authorization process.
- **Vision Procedural Changes:**
 - Conversion of Medi-Cal Healthcare Common Procedure Coding System (HCPCS) Level III interim codes to national HCPCS Level II and Physician’s Current Procedural Terminology (CPT) Level I codes.
 - Elimination of vision qualifying codes and the use of national modifiers.

Instructor-Led Seminars for Upcoming Vision Changes

Providers can access the upcoming dates and locations for Vision Seminars by visiting the Medi-Cal Web site (www.medi-cal.ca.gov) and clicking the “Education & Outreach” link on the left-hand navigation bar and then the “Medi-Cal Instructor-Led Seminars” link.

Self-Service HIPAA Transaction Utility Tool

A self-service environment HIPAA Transaction Utility Tool is available for submitters. The utility tool offers transaction validation (inclusive of Companion Guide-level editing), troubleshooting and reporting features that enhance, but do not replace, Medi-Cal’s current testing and media activation requirements. Vision electronic claim submitters have been notified via letter of utility availability, with instructions on how to use it.

Please see **Vision Care Changes**, page 8

Vision Care Changes (*continued*)**Electronic Attachments**

New attachment submission options to expedite claims processing are available to providers or submitters. Providers now have the ability to submit fax and electronic attachments with 837 v.4010A1 electronic claim submissions. This new functionality allows providers to submit electronic claims and fax their attachments, or send the attachments electronically through an approved third-party vendor. An approved list of third-party vendors available for electronic attachment submissions will be announced in a future *Medi-Cal Update*.

In addition to faxing them, providers may also send hard copy attachments by mail. For details on how to send attachments, along with the address to mail the attachments to, please refer to the *Billing Instructions* section of the *837 Version 4010A1 Health Care Claim Companion Guide* on the Medi-Cal Web site (www.medi-cal.ca.gov) by clicking the “HIPAA” link on the home page, then the “ASC X12N Version 4010A1 Companion Guides and NCPDP Technical Specifications” link, and then the “Billing Instructions” link.

The “837 Version 4010A1 Electronic Claims with Attachments Now Available” article published in the January 2006 *Medi-Cal Update* is also available for reference. You may access the article by clicking the “HIPAA” link on the Medi-Cal home page and then the “Electronic Transactions: Biller Updates” link.

Additional Resources

For more information, in-state providers may call the Telephone Service Center (TSC) at 1-800-541-5555, 8 a.m. to 5 p.m., Monday through Friday. Border providers, software vendors and out-of-state billers who bill for in-state providers should call (916) 636-1200.

**New Vision Care Treatment Authorization Request (TAR) Process Effective July 1, 2006**

Effective for vision services performed on or after July 1, 2006, the *Payment Request For Vision Care and Appliances* (45-1) claim form will no longer be used to request prior authorization for medically necessary contact lenses, low vision aids and other non-Prison Industry Authority covered items.

Instead of the 45-1 claim form, providers will use the 50-3 *Treatment Authorization Request* (TAR) form to submit prior authorization requests for eye appliances services performed on or after July 1, 2006. A draft of this form is included with this bulletin.

The 50-3 TAR form is available and can be ordered by contacting the Telephone Service Center (TSC) at 1-800-541-5555. **However, the 50-3 TAR form cannot be used to request authorization for any service performed prior to July 1, 2006.** Please continue to follow current procedures using the 45-1 claim form to request prior authorization for dates of service prior to July 1, 2006.

New Authorization Process

The current authorization process requires that an original 45-1 claim form be mailed to the Vision Care Policy Unit (VCPU) for authorization. Effective for vision services performed on or after July 1, 2006, the 50-3 TAR form and associated documentation can be mailed or faxed to:

California Department of Health Services
Vision Care Policy Unit
MS 4600
P.O. Box 997413
Sacramento, CA 95899-7413
VCPU Fax Number: (916) 552-9077

Please see Vision Care TAR, page 9

Vision Care TAR (continued)

Providers should see an improved response and turnaround time for authorizations since the new TAR process allows faxed TAR submissions and responses.

Upon completion of the authorization review process, the VCPU will fax (if a valid fax number is included on the form) or mail the 50-3 TAR form back with a decision (Approved as Requested, Approved as Modified, Denied or Deferred). All TARs are assigned a TAR Control Number (TCN) and Pricing Indicator (PI) on the 50-3 form. Claims for approved services must include a valid TCN and PI for payment. The assigned TCN and PI are also required for resubmission of deferred TARs.

Specific instructions about how to use the 50-3 TAR form and how to submit claims of approved services for payment will be addressed at Medi-Cal instructor-led seminars and future *Medi-Cal Updates*. For a schedule of upcoming seminars, please call the TSC or visit the Medi-Cal Web site at www.medi-cal.ca.gov and click “Education and Outreach” and then “Medi-Cal Instructor-Led Seminars.”

SCREEN 10% STATE USE ONLY

SCREEN 15% 4

CONFIDENTIAL PATIENT INFORMATION FOR F.I. USE ONLY

40 ☐ 41 ☐
42 ☐ 43 ☐

C.C.N.

TREATMENT AUTHORIZATION REQUEST
STATE OF CALIFORNIA DEPARTMENT OF HEALTH SERVICES

(PLEASE TYPE) FOR PROVIDER USE (PLEASE TYPE)

VERBAL CONTROL NO. 2 ☐ DRUG ☐ OTHER ☐ REQUESTED RETROACTIVELY ☐ YES ☐ NO ☐ YES ☐ NO ☐ PROVIDER PHONE NO. () PROVIDER FAX NO. ()

PROVIDER NAME AND ADDRESS

3. PROVIDER NUMBER

PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS:

FOR STATE USE

33 PROVIDER: YOUR REQUEST IS:
☐ APPROVED AS REQUESTED ☐ DENIED ☐ DEFERRED
☐ APPROVED AS MODIFIED (IT MUST BE MARKED BELOW AS AUTHORIZED MAY BE CLAIMED) ☐ JACKSON VS RANK PARAGRAPH CODE

BY MEDICAL CONSULTANT I.D. # DATE REVIEW COMMENTS

34 ☐ 35 ☐ 36 ☐ 37 ☐ 38 ☐ 39 ☐ 40 ☐ 41 ☐ 42 ☐ 43 ☐ 44 ☐

COMMENTS/EXPLANATION

RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51000 (b)

35 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐

LINE NO.	DATE	APPROVED DATE	SPECIFIC SERVICE REQUESTED	QUANTITY	REASON FOR REQUESTING	QUANTITY	CHARGE
1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

SIGNATURE OF PHYSICIAN OR PROVIDER TITLE DATE

AUTHORIZATION IS VALID FOR SERVICES PROVIDED FROM DATE TO DATE

TAR CONTROL NUMBER PI

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE PATIENT'S ELIGIBILITY IS CURRENT BEFORE RENDERING SERVICE. SEND TO FIELD SERVICES (F.I. COPY)

SEE YOUR PROVIDER MANUAL FOR ASSISTANCE REGARDING THE COMPLETION OF THIS FORM.

New Treatment Authorization Request (50-3) Form

Instructions for Manual Replacement Pages

Part 2

April 2006

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Remove and replace: anest 1/2
cal child sar 5/6
can detect 5 thru 12

At the end of the *Cancer Detection Programs: Every Woman Counts* section:

Remove: Recipient Eligibility Form A & B (English)
Recipient Eligibility Form A & B (Spanish)
Insert: Recipient Eligibility Form (English version)
Recipient Eligibility Form (Spanish version)

Remove: cif co 1 thru 10
Insert: cif co 1 thru 11

Remove and replace: medi cr op 7/8 *
path an over 7
presum 5/6
tar and noncd9 1/2 *

* Pages updated due to ongoing provider manual revisions.